

difference observed between groups was mostly explained by reductions in pathology errors and follow-up errors and not by improvements in endoscopist performance.

**Conclusion** Missed diagnosis rates at our institution are within the ranges reported in other studies of Western populations. Performance was not significantly improved by concentrating the practice of UGI endoscopy into specialist hands.

**Competing interests** None declared.

**PMO-192 A RETROSPECTIVE COMPARISON OF THE PERFORMANCE OF OLYMPUS Q SERIES COLONOSCOPES AND PENTAX HILINE AT SCREENING COLONOSCOPY**

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**Introduction** There is a small rate of interval cancer after colonoscopy partly due to incomplete lesion detection during the procedure. Some studies have shown superior lesion detection with improved endoscopic image quality and enhancement<sup>1, 2</sup> with one suggesting a 50% increase in polyp detection with Pentax HiLine (PH) over Olympus Lucera series (OL) colonoscopes. We have compared the performance of these two systems.

**Methods** All complete bowel cancer screening colonoscopies performed by a single endoscopist between 18 March 2010 and 27 September 2011 in faecal occult blood test positive patients (n=483) were analysed for insertion/withdrawal time, patient comfort/sedation doses and lesion detection (total polyps, adenomas, advanced, right sided). Comparisons were made between OL (white light) and PH (white light high definition on insertion, i-scan 1 on withdrawal). Differences between groups were analysed using either the Mann-Whitney U test or  $\chi^2$  test.

**Results** Completion rates were similar (OL 413/425; 97.2% and PH 55/58; 94.9%, p=0.24). The two groups were matched for age and sex. Adenoma detection rates were comparable (49% vs 56%, p=0.38). There was no significant difference in terms of mean insertion time, withdrawal time in normal colonoscopies, total numbers of polyps, adenomas, proximal adenomas or advanced adenomas (>1 cm, villous, with high grade dysplasia or containing cancer). The sample size gave an 88% power to detect the higher polyp detection rate detected previously.<sup>2</sup> There was a small statistically significant increase in nurse reported patient discomfort with PH (0.5 vs 1, p<0.0001—none=0, minimal=1, mild=2, moderate=3, severe=4) with higher requirements for Midazolam and similar Fentanyl doses.

**Conclusion** In this uncontrolled single endoscopist series in a homogenous group of patients, there did not appear to be a significant benefit of one system over the other in terms of procedure duration or lesion recognition. PH colonoscopes did appear to lead to a slight increase in patient discomfort and sedation requirements. A randomised controlled trial is required to establish the relative performances of these systems.

Abstract PMO-192 Table 1

	Mean (SD)		p Value
	Pentax	Olympus lucera	
Fentanyl dose ( $\mu$ g)	61.4 (18.5)	57.5 (18.0)	0.13
Midazolam dose (mg)	2.4 (0.7)	2.1 (0.6)	0.035
Comfort score	1.0 (0.6)	0.5 (0.6)	<0.0001
Insertion time (min)	11.6 (7.5)	11.1 (6.6)	0.93
Withdrawal time* (min)	14.7 (8.0)	15.6 (8.2)	0.20
Total polyps	1.6 (1.7)	1.4 (2.0)	0.19
Total/proximal adenomas	1.1 (1.3)/0.4 (0.7)	1.0 (1.5)/0.4 (0.9)	0.28/0.74
Advanced adenomas	0.3 (0.5)	0.4 (0.7)	0.64

\*In normal colonoscopies.

**Competing interests** None declared.

**REFERENCES**

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**PMO-193 OUTCOME OF NON-COMPLIANCE WITH A PROGRAMME OF VARICEAL SCLEROTHERAPY IN A DGH**

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**Introduction** Bleeding from oesophageal varices is a serious medical emergency which can be prevented by endoscopic variceal ligation either as primary or secondary prophylaxis. We aimed to establish the degree of compliance with scheduled endoscopic therapy, the reasons for non-compliance and the clinical consequences.

**Methods** We examined the medical notes and endoscopy reports of 50 cirrhotic patients with oesophageal varices who underwent endoscopic band ligation at the Great Western Hospital over the last 3 years. We categorised the patients into two groups: those whose were followed up in accordance with BSG guidelines on the scheduling of oesophageal sclerotherapy and those whose follow-up fell short of these standards. We assessed the incidence of variceal haemorrhage in the two groups and investigated the reasons of inappropriate follow-up.

**Results** 50 patients underwent 229 endoscopy procedures for varices during the 3-year period. Of these, 45 endoscopies were performed outside the recommended time schedule: 25 were booked incorrectly; 12 were booked correctly but experienced a delay; 8 were both booked incorrectly and further delayed. 20 patients died (none from haemorrhage). Of the 18 out of 50 patients who were followed up appropriately none experienced re-bleeding. Among the group who were non-compliant with the recommended scheduled for whatever reason (45 delayed procedures in 32 patients) three patients underwent five admissions for GI bleeding during follow-up. Secondary prophylaxis after a first variceal haemorrhage was performed in 18 patients of who 9 were non-compliant with guidelines; 6 of these were due to non-attendance and 3 due to delays in booking due to pressure on appointments.

**Conclusion** There is a clear difference in outcomes between those whose variceal bleed is followed up in a timely way with repeat endoscopy as per BSG guidelines and those who, for whatever reason, are non-compliant with the guidelines. Emphasis must be placed on correct booking procedures and efforts made to contact patients about imminent appointments to minimise morbidity and mortality from variceal rebleeding.

**Competing interests** None declared.

**PMO-194 POLYPOID LESIONS IN THE UGI TRACT IN PATIENTS WITH PORTAL HYPERTENSION; EUS BEFORE YOU BIOPSY!**

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**Introduction** The universal use of upper gastrointestinal (UGI) endoscopy in patients with portal hypertension in combination with increasing number of patients with liver disease has resulted in the detection of indeterminate upper GI lesions, other than obvious varices. Many of these lesions are found incidentally and biopsying them presents a dilemma for the endoscopists, as this may lead to serious complications. The aim of this retrospective study was to

assess the nature of such lesions using endoscopic ultrasound (EUS) prior to a biopsy.

**Methods** A total of 22 consecutive patients with portal hypertension who underwent an EUS evaluation between June 2008 and November 2011 for upper GI polypoid lesions found on endoscopy were included in the study. Procedure and pathology reports, obtained from patients' electronic records, were reviewed.

**Results** Of the 22 patients (16 men, 6 women, median age 66) who underwent upper GI endoscopy, 11 had lesions in the proximal stomach (gastro-oesophageal junction, fundus, gastric body) while eight had lesions in the distal stomach (antrum, pylorus) and three in the duodenum. Six (27.3%) proved to be varices and 4 (18.2%) polypoid lesions over varices (2 benign, 2 malignant). Whereas, 7 (31.8%) patients had true polyps. The remaining lesions found on EUS included 1 (4.5%) case of gastric fold, 1 gastric antral vascular ectasia (GAVE), one ulcer, 1 case of external compression and one patient had a normal EUS with no lesion seen. Of the 10 cases of varices and varices underlying polypoid lesions, 8 (80%) were in the proximal stomach. Histology of non-vascular lesions under EUS were available in 11 patients, which showed 5 (45.5%) inflammatory polyps, 2 (18.2%) adenocarcinoma, 2 (18.2%) adenoma, 1 (9.1%) normal and one was reported as insufficient sample.

**Conclusion** Indeterminate upper GI lesions encountered during routine endoscopy in patients with portal hypertension are commonly either varices or may develop around varices. We recommend EUS evaluation prior to biopsying such lesions in order to avoid potential serious complications such as iatrogenic variceal bleed.

**Competing interests** None declared.

### PMO-195 IS THERE OPTIMUM PERIOD OF OBSERVATION POST DAYCASE ERCP? 12 MONTH EXPERIENCE IN A LARGE NON-TERTIARY CENTRE

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**Introduction** Daycase ERCP is practised in approximately 50% centres in UK. Even in these centres there is no uniform policy for post ERCP observation or duration of hospital stay. We established daycase ERCP service in January 2010 on the Wirral, catering to 360 000 population and hereby present our experience over a 12-month period.

**Methods** Data from Unisoft, GI Endoscopy reporting tool, was analysed to identify all the daycase ERCPs performed from 1 January to 31 December 2010. All the patients who for any reason stayed overnight after ERCP or re-attended hospital within 7 days, were identified from day ward registry and patient administrative system. Medical notes of all these patients were reviewed. All patients were closely monitored post ERCP in medical day ward for 4 h and were then allowed to eat and drink if there were no concerns. All patients were seen by the ERCPist prior to discharge.

**Results** Total of 395 ERCPs were performed by three endoscopists in this period of which 195 (48%) were as daycases. Difficulty level in all cases was Level 1–2 as per Cotton *et al.* Indication of ERCP was pancreato biliary malignancy in 29 (15%), stone disease in 160 (82%) and previous bile leak 6 (3%) patients. All procedures in our unit are done with therapeutic intent. 137 (72%) patients underwent sphincterotomy and/or stent insertion. Previously placed stents were removed in the rest along with balloon trawl/stone extraction as needed. In all 32 (16.4%) patients were admitted overnight. Of these, 13 (6.6%) were elective admissions due to patient choice such as those who were elderly and lived alone. There were 7 (3.5%) complications including 3 mild cholangitis, 1 moderate cholangitis, 1 mild and 1 severe pancreatitis and 1 death as per accepted guidelines by Cotton *et al.* One patient who died, chose to stay back electively

but died 12 h later with pulmonary embolism. Rest 13 (6.6%) cases were advised to stay overnight because of suspected adverse event (commonest being post ERCP pain in 10 cases) but this was not substantiated on further investigations. Only one out of 195 patients (0.5%), presented within 7 days with procedure related complication, namely mild cholangitis. Overall there were 8 (4%) complications in 195 daycase ERCPs. Out of these 8, only 2 (25%) presented within 0–2 h, 4 (50%) in 2–6 h and rest 2 (25%) after 12 h of the procedure.

**Conclusion** Daycase ERCP is a safe service. We propose that patients should be kept nil by mouth for 4 h post procedure and observed upto 6 h on the daycase unit. It is good practise for patients to be seen by the ERCPist prior to discharge. This would pick up majority of procedure related complications and enhances patient satisfaction.

**Competing interests** None declared.

### REFERENCE

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### PMO-196 REDUCING TIME TO GASTROSCOPY IN UPPER GASTROINTESTINAL BLEEDING

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**Introduction** Approximately 300–350 patients present to Colchester General Hospital with an upper Gastrointestinal (GI) bleed per year. Guidelines advise endoscopy within 24 h of presentation. To improve our performance, we introduced a new system for prioritising these requests and monitored the results with repeated audits.

**Methods** An audit of all upper GI bleed cases was conducted over the same 3-month period (March–May) in 2009, 2010 and 2011. For each case we obtained the times of admission, Oesophagogastroduodenoscopy (OGD) request, procedure and discharge. The discharge summary, and where necessary the notes, were consulted to separate cases admitted for bleeding from those where bleeding occurred after admission for another reason. The main theatre logs were consulted for numbers of emergency out-of-hours OGDs. In an effort to tackle to poor waiting times, the Early Morning Bleeder (EMB) system was introduced in July 2009. Two slots are allocated daily (excluding weekends) for gastroscopy for cases of upper GI bleeding at the beginning of the working day. Requests are collected in a box in the Medical Assessment Unit daily at 0730. The Rockall Score is used for prioritisation. These three audits thus compare the situation before and after introducing the EMB system.

### Results

	2009	2010	2011
Total cases	72	80	85
Bleeder admissions	54	59	53
Wait from admission to OGD (days)	0	1	≥2
Mean wait for OGD (days)	3.26	1.95*	1.66*
Median length of stay (days)	6	4	3*

\*p<0.05 compared to 2009.

Waits were significantly longer for cases admitted on Friday or Saturday.

Numbers of out of hours OGDs for bleeding were 12 (2007) and 11 (2008) before the EMB and 7 (2010) and 6 (2011) afterwards.

**Conclusion** The EMB system has reduced waits from presentation to OGD and length of hospital stay for patients presenting with upper GI bleeds. Patients are probably safer as the number of out of hours OGDs has fallen. There are plans to extend the service to include